Chapter One - Measures of NHI Implementation

In order to assess how fully the Health Care Financing Administration (HCFA) and the States have implemented the Nursing Home Initiative (NHI), we selected several initiatives for which we could readily obtain data. The initiatives examined for this report are: 1) implementation of a staggered schedule for nursing home recertification surveys; 2) giving facilities with a history of noncompliance no opportunity to correct before imposition of enforcement remedies; 3) allowing reasonable assurance periods before re-admitting terminated nursing homes to the Medicare program; 4) increased scrutiny of special focus facilities; and, 5) implementing a streamlined process for investigating complaints in which allegations were raised.[1]

1.1 Staggered Surveys

The goal of unannounced surveys is to get an accurate picture of the quality of care being provided in the nursing home. Theoretically, surveys can begin on any day of the week. The staggered survey initiative sought to correct the practice, as highlighted in our 1998 Report to Congress *"Study of Private Accreditation (Deeming) of Nursing Homes, Regulatory Incentives and Non-regulatory Initiatives, and Effectiveness of the Survey and Certification Process"* (1998 Report to Congress), of conducting nursing home recertification surveys essentially only during business hours Monday to Friday. Anecdotally, some consumer advocates and nursing home staff advised us that the timing of the annual surveys was wholly predictable. In October 1998, State survey agencies were instructed to vary the starting time of recertification surveys in nursing homes so that surveyors could observe nursing homes -- particularly their levels of staffing and how they provided care -- during hours apart from normal Monday to Friday business hours. To accomplish this, surveyors were asked to begin 10 percent of the nursing home recertification surveys on the weekend or during evenings and nights. These instructions were issued in the January 1999 Formal State Operations Manual.

Table 1 presents the percentage of surveys from 1998 - 1999, by calendar quarter, that began on the weekend or at night. (State-level data are presented in Appendix C). The data are from OSCAR, our survey and certification administrative database, and are entered by each State. The data indicate whether a survey began during "off-hours," that is either before 8 a.m., after 6 p.m., or on the weekend. Based on conversations with States and our Regional Offices, we believe that States began to implement off-hour surveys in early 1999, but most States did not begin entering off-hour surveys in the

[1]Although this change in protocols was introduced in March 1999, several months after the initial set of initiatives were introduced, it is still being considered one of the Nursing Home Initiatives for the purpose of this study.

OSCAR database until the third quarter of calendar year 1999. For this report, morning and the evening surveys are grouped together.

Table 1. Percentage of Nursing Home Recertification Surveys Conducted during Weekends and Evenings

Time Period	Night Surveys N (%)	Weekend Surveys N (%)	Weekend + Night N (%)
1998 Qrtr. 1	6 (0.2%)	0 (0.0%)	6 (0.2%)
1998 Qrtr. 2	10 (0.2%)	4 (0.1%)	14 (0.3%)
1998 Qrtr. 3	15 (0.4%)	7 (0.2%)	22 (0.5%)
1998 Qrtr. 4	22 (0.6%)	14 (0.4%)	36 (1.0%)
1999 Qrtr. 1	47 (1.2%)	44 (1.1%)	91 (2.3%)
1999 Qrtr. 2	73 (1.8%)	56 (1.4%)	129 (3.1%)
1999 Qrtr. 3	82 (2.2%)	52 (1.4%)	134 (3.6%)
1999 Qrtr. 4	152 (4.8%)	101 (3.2%)	253 (8.1%)

Source: HCFA analysis of OSCAR data reported through March 23, 2000

As indicated in Table 1, States are reporting that, since January 1998, a steadily increasing number of surveys began in off-hours. In the first quarter of 1998, 0.2 percent of surveys began in off-hours, and, in the fourth quarter of 1999, the percent of surveys which began during off-hours increased to 8.1 percent. While this percentage is shy of the 10 percent target we set in the NHI, it is a significant improvement over previous rates. As shown in Appendix C, during the fourth quarter of 1999, 14 States reported that 10 percent or more of the nursing home recertification surveys began on a weekend or during the evening or weekend (data not shown here). On the other hand, 17 States reported that they had begun less than 1 percent of the surveys off hours.

However, in reviewing the State-level data as of June 2000, we identified 17 States (Connecticut, Massachusetts, Maine, Vermont, New Jersey, Maryland, Arkansas, Texas, New Mexico, Missouri, Nebraska, Wyoming, California, Hawaii, Nevada, Oregon, Washington) where off-hour surveys comprise fewer than 7 percent of surveys. In August 2000, we wrote a letter to the State agency directors of these States to encourage them to improve their record and to isolate the reasons for their inability to comply with this initiative. State agencies were asked to identify the reasons for their low performance, their plans for improvement, and suggest ways we could assist them in reaching the 10 percent off-hour survey goal. We requested a response by September 8. Their responses will help us to more carefully focus our efforts to assist these States than we have been able to in the past.

In conclusion, it appears that, although we were close to achieving the national target of 10 percent by the end of CY 1999, this initiative has been only partially implemented. A number of States appear not to have implemented this initiative, or are slow to report to OSCAR that they have conducted these surveys. We will continue to monitor implementation of the off-hours surveys and follow up with States that have been slow to implement this initiative.

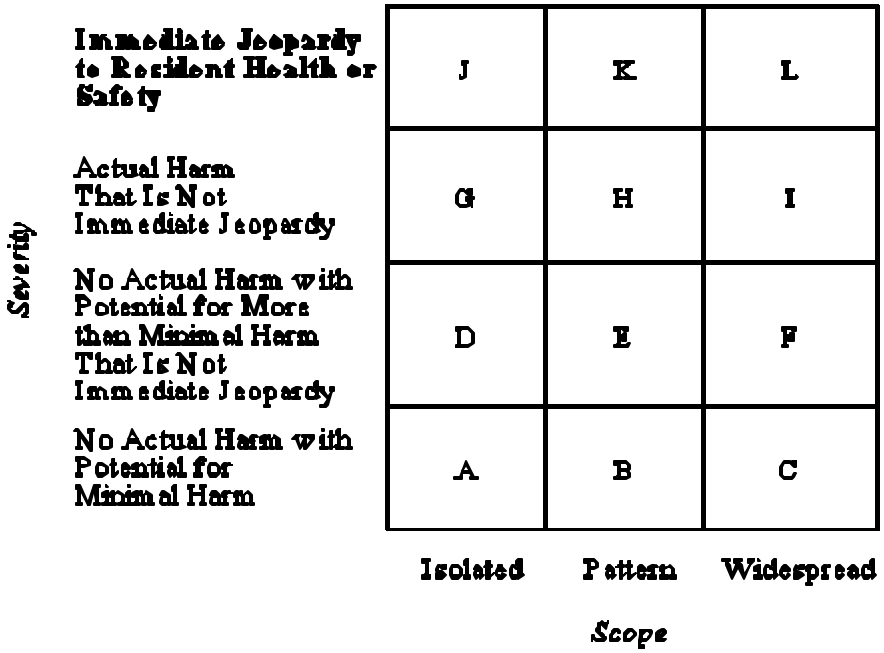
This analysis does not address whether or not the results of surveys conducted during off hours are different from the findings of surveys conducted during normal business hours. A reasonable hypothesis is that off-hour surveys would be more likely to result in findings of insufficient nursing home staffing, for example. That analysis will be addressed in a subsequent report.

1.2 Facilities that are not given an opportunity to correct deficiencies before enforcement remedies are imposed

One of the general criticisms of the survey and certification enforcement process is that it may inappropriately allow nursing homes with severe, life-threatening deficiencies to correct those deficiencies and avoid the imposition of any enforcement penalty. Although we have instructed States, since the implementation of the enforcement regulation in July 1995, to impose immediate enforcement penalties on nursing homes that receive deficiencies of scope and severity "H" or higher during two successive standard surveys, our 1998 report found that this was often not occurring, and, furthermore, that it might not be producing the desired effect. (An "H" level deficiency is one that has caused actual harm to several nursing home residents. A "G" level deficiency is one that has caused actual harm to one resident or a very small group of residents. See Figure 1.) Therefore, we lowered the level at which immediate penalties must be imposed. In January 2000, we modified the policy so that facilities that received successive "G" level deficiencies were immediately sanctioned. We published this guidance in the Survey and Certification State Operations Manual in January 2000.

As a result, if surveyors find, in two consecutive standard surveys, that nursing homes have caused actual harm, immediate sanctions against the nursing home should be imposed. Under other circumstances, nursing homes that have caused actual harm may be given a period of time to correct the deficiency before enforcement penalties are imposed.

Figure 1. Scope and Severity Grid for Rating Nursing Home Deficienc



Th e purpose of this
se ction is to report
th e extent to which
St ates are referring
th ese severely-
de ficient nursing
ho mes to the
R egional Offices or
to their State
M edicaid agencies.
Th is analysis does
no t assess the
ap propriateness of
th e penalties
ac tually levied. For
thi s report, a group
of 56 Medicare-

participating nursing homes and ten Medicaid-only nursing homes that have received deficiencies at level "H" or higher on two consecutive standard surveys was identified. The Regional Offices were then asked to report on the number of nursing homes from that group that had been referred to them by the States. (States are not obligated to report Medicaid-only facilities to the Regional Offices). H level deficiencies were selected because the current policy of imposing sanctions on nursing homes with double-G level deficiencies was communicated to States in January 2000 and adequate data were not available at the time this report was prepared.

Of the 56 Medicare-participating nursing homes, 53 (94.6 percent) were referred by the States to the HCFA Regional Offices for the imposition of enforcement remedies. Of the three facilities that were not referred, one was in California and represented 14.3 percent of the California SNFs in the group, one was in Oregon (50 percent of Oregon SNFs in the group), and one was in Washington (25 precent of Washington State SNFs in the group). These three facilities were back in compliance when the Regional Offices contacted the States to follow up, and therefore no referral was made. This represents an improvement over the rate of such referrals when we assessed this issue in 1998. The relevant Regional Offices have contacted California, Oregon, and Washington to determine why they failed to follow the policy in the sample cases. All nine Medicaid-only nursing facilities were referred to the State Medicaid agencies for enforcement action.

1.3 Adequate Reasonable Assurance Periods in the Medicare Program

After a nursing home has been terminated for failing to meet Federal requirements, a period of time must pass before it can be readmitted to the Medicare program. This time period is called the "reasonable assurance" period. The examination of adequate reasonable assurance periods was carried out in response to concerns about the potential for nursing homes that were terminated because of poor quality of care to apply for relatively quick re-entry into the Medicare program. Questions have been raised about the adequacy of safeguards to prevent substandard facilities from re-entering the program.

In theory, several protections exist to prevent nursing homes that have lost Medicare certification from re-entering the Medicare program without adequate demonstration of compliance. Regional Offices impose a waiting period on nursing homes and also require nursing homes to attain at least substantial compliance on a new survey before being considered for re-certification.

In order to assess the extent to which involuntarily terminated nursing homes are re-entering the Medicare program and to see if the Regional Offices are imposing adequate reasonable assurance periods on these nursing homes,[2] we asked the Regional Offices to provide the dates of termination for

[2]Currently, no waiting period is imposed on terminated facilities before they can reapply for participation in the Medicaid program. HCFA has drafted a legislative proposal that, if adopted, will impose waiting periods on terminated facilities seeking Medicaid re-certification.

nursing homes terminated within the last year. We also asked the Regional Offices to supply the current status of the nursing home, the date of reapplication to the program, and the date of re-certification if the nursing home had re-entered the Medicare program.
Of the 33 involuntarily terminated Medicare-only and dually participating nursing homes,[3] 10 have been readmitted. Of these, the average time between termination and re-entry was 5 months. The shortest period of time was three and one-half months, while the longest was nearly 8 months.

These findings show that few nursing homes terminated from the Medicare program in the last year have reapplied for certification. However, this analysis only considered nursing homes terminated within the last year and does not address whether or not the decisions made in these particular cases were reasonable.

1.4 Special Focus Facilities

Special Focus Facilities comprise a group of nursing homes selected by each State from a list of candidates prepared by HCFA. These nursing homes receive standard surveys every 6 months, rather than approximately annually under usual practice. The purpose of this program is to provide a higher level of scrutiny to some nursing homes, without reducing oversight of other nursing homes. It is hoped that the additional level of review by the State survey agency will bring these nursing homes into compliance with Medicare and Medicaid conditions of participation and will help them remain in compliance.

HCFA provided a short list of facilities, based on survey findings as reported in the OSCAR system in November 1998, to States from which they could select two for special enforcement. To develop the initial list of candidate facilities, HCFA counted the number of deficiencies for each facility that had been cited at a scope and severity of F or higher, and then assigned a weighted score to each deficiency based on the scope and severity finding. Scores for substandard quality of care citations were doubled. HCFA also counted the number of substantiated complaints each facility had received in the 2 years prior to November 1998. The total score for each facility consisted of the sum of the weighted deficiencies and the weighted complaint score. Scores were then ranked by State, and the four highest scoring facilities for each State were selected, with ties included. The States then chose at least two facilities from the four that HCFA had selected for the list.

Facilities will remain on the list until they achieve substantial compliance on two successive standard surveys or until their provider agreement is terminated. At the beginning of each year, HCFA will select a new set of candidate facilities, using the methodology used previously to select the list. Again, each

[3] A dually participating home is one that participates in both (Medicare and Medicaid) programs. A total of 41 nursing homes (Medicare-only, Medicaid-only, and dually participating) were involuntarily terminated from the Medicare and Medicaid programs in calendar year 1999.

State will choose at least two facilities from the list, with Regional Office approval. As of April 2000, States report that they have conducted semiannual surveys on 60 of the original 107 facilities on the list.

Efforts so far have resulted in 12 of these nursing homes being terminated or voluntarily withdrawing from the Medicare and Medicaid programs. Civil Money Penalties were imposed on 31 of the facilities, and 24 facilities received a Denial of Payment for New Admissions. We do not have comparable data on many of these enforcement actions for other nursing homes in the country, and, as a consequence, these rates are difficult to compare directly. We do know that these nursing homes experience a much higher rate of termination (approximately 10 versus 0.2 percent for other nursing homes) and rate of substandard quality of care determination (8 versus 5 percent) than do Medicare- and Medicaid-certified nursing homes as a group. States report that 28 of these facilities are now in substantial compliance. A comparison of survey results from the most recent and immediately-preceding surveys shows that the average number of deficiencies found has decreased slightly and that there has been a decrease, from 66.2 to 50 percent, in the percentage of Special Focus Facilities found with G level or worse deficiencies. It is difficult to judge whether or not these measures have been effective in bringing these nursing homes into compliance without comparing them to a comparable group of nursing homes. This analysis will be addressed in a subsequent report.

Where it has been implemented, this initiative appears to have been successful in either bringing many of these nursing homes -- which have a history of severe noncompliance -- into substantial compliance, or removing them from the Medicare or Medicaid programs. These results suggest that increased scrutiny of problematic nursing homes can be successful in achieving enforcement results.

Unfortunately, these findings also suggest that the Special Focus Facility policy has not been fully implemented. We are concerned that States have only been able to conduct semiannual surveys on a little more than half of the Special Focus Facilities. The States that failed to follow the instruction to conduct semiannual surveys of all Special Focus Facilities are as follows: Connecticut, Maine, Rhode Island, New York, Puerto Rico, Washington, DC, Delaware, Pennsylvania, Virginia, West Virginia, Florida, Georgia, Kentucky, Mississippi, Tennessee, Ohio, Arkansas, Louisiana, New Mexico, Oklahoma, Texas, Nebraska, Colorado, Montana, North Dakota, California, Nevada, Alaska, Oregon and Washington. We will continue to work closely with State survey agencies to assure that all of these facilities are surveyed every 6 months. In May 2000, the Regional Offices and States were reminded in writing of the inspection requirements for this group of facilities.

1.5 State Survey Agency Implementation of Revised HCFA Complaint Policies - Summary Report of E-mail Questionnaire[4]

[4]This study was conducted by Catherine Hawes, Meyers Research Institute, Menorah Park Center for the Aging, and Alan Steggeman, Center for Health Services Research and Analysis, University of Wisconsin, Madison. The results of this study are contained in Appendix B.

In addition to routine unannounced surveys, HCFA and the State survey agencies respond to specific complaints from residents. In addition to our other Nursing Home Initiative activities, HCFA also initiated a series of actions to improve the investigation of complaints in nursing homes. HCFA committed to conducting investigations of potential actual harm to residents in 10 days. We also reiterated our commitment to investigate complaints of immediate and serious threat to resident health or safety within 2 days.

This policy was announced to all States in a letter sent March 16, 1999. To operationalize the policy, a HCFA/State workgroup was formed. The workgroup concluded that Medicare and Medicaid resources -- both staff and funds -- were not immediately available to provide for the investigation of all allegations of actual harm within 10 days. For Medicare, additional funds needed to be allocated to the survey agencies. In addition, survey agencies would have to have Medicaid matching funds and staff approved by the legislature. Since immediate increases in funds or staff were unlikely, the workgroup focused on developing operational guidance on triaging complaints and, within 10 days, investigating complaints of higher levels of actual harm. This operational guidance was issued on October 13, 1999. The Regional Offices were to work with States to ensure implementation of the guidelines.

Since the fiscal year 1999 and 2000 budgets did not provide for additional funds for complaint investigations, HCFA requested and received authorization from Congress to reprogram Medicare contractor funds to the survey and certification budget. For fiscal year 1999, $4 million was reprogrammed, but few States received approval from State legislatures for additional staff or Medicaid funds. For fiscal year 2000, $5 million was reprogrammed and distributed to States. For fiscal year 2001, the President's budget for the Medicare survey and certification system includes $10.1 million for investigations of complaints of potential actual harm in nursing homes within 10 days.

In a further effort to prevent abuse and neglect of residents, we initiated a study to identify steps HCFA and the States could take to strengthen the nursing home complaint process. To achieve this, the study will describe States' processes for complaint investigation, assess the effectiveness of these processes and make recommendations for specific actions we and the States could take to improve complaint investigations and to prevent abuse, neglect, and theft of residents' property; determine how to make the complaint process more responsive to residents and their families; and, make recommendations about how to improve the ongoing monitoring and oversight of the complaint investigation process by HCFA and the States. Researchers from the Center for Health Systems Research and Analysis (CHSRA) at the University of Wisconsin-Madison and the Myers Research Institute at Menorah Park Center for Senior Living are conducting this study. The final report is scheduled to be delivered in January 2001.

The study involves focus groups and extensive interviews, through mail and telephone surveys, with key stakeholders in the complaint investigation process, including State survey agencies, ombudsman programs, and consumer advocacy groups in all 50 States, the District of Columbia and Puerto Rico. Focus groups and in-person interviews also are being conducted with residents, their families, nursing

home administrators and other staff. Interviews may also be conducted with State and Federal agencies, such as HCFA Regional Offices, Offices of the Attorney General, and professional licensing boards. In addition, actual complaints will be analyzed as part of assessing the effectiveness of current processes. The study will also analyze case examples of abuse and neglect to evaluate State responses and estimate the utility of the researcher's recommendations. Finally, site visits and in-depth analysis of model complaint investigation processes and programs designed to prevent abuse and neglect will be conducted.

As a preliminary step, to gather information from the State survey agencies for the purpose of responding to Congressional inquiries, a brief e-mail questionnaire was sent to all State survey agencies regarding how they have implemented recent HCFA policy changes on the timing and procedures for complaint investigations, as detailed in letters dated March 16 and October 13, 1999.

The questionnaire was sent to all State survey agency directors on March 29, 2000, with a requested response by April 4, 2000. Follow-up telephone and/or e-mail contacts were made with agencies that had not responded by the deadline. Forty-eight of 52 survey agencies responded to the questionnaire.

Overview of Key Findings From the Survey[5]

Since releasing complaint guidance to the State survey agencies, we have seen a significant increase in the attention being given to nursing home complaints. States have increased survey resources, made organizational changes and process improvements, and upgraded information systems in order to bring more focus to this area.

Because of budget and staffing issues, some States have not been able to meet timeliness thresholds on 100 percent of the actual-harm complaint cases; however, we are confident that the States are aware of our intentions and are working to achieve the goals and objectives.

Regional Office (RO) Guidance and Assistance (Question 1.)

The March 16, 1999, letter from HCFA stated that: "through HCFA's Regional Offices, we will help State agencies set priorities in carrying out these responsibilities." Likewise, the October 13, 1999, letter stated:

> To further assist implementing this guidance, key staff from each HCFA Regional Office will be meeting with the State survey agencies to discuss triage and prioritization of complaints, facilitate sharing examples of best practice complaint management, and discuss the manner in which implementation of this guidance will be evaluated.

[5]For a full discussion of the survey results, see Appendix B.

Despite this guidance, the majority of States reported that the Regional Offices (ROs) did not adhere to the guideline established by HCFA's Central Office. With perhaps the exception of Region VII, specific contact between State survey agencies and the Regional Offices to clarify this complaint guidance was reported to be "spotty", both in terms of contacting all States in a region as well as providing the States with direction as to how the Regional Offices will evaluate their performance. Over half the States reported that the Regional Offices had not contacted them, and in two Regions (Regions II and IX) none of the responding States reported that the Regional Offices had contacted them. Furthermore, combining the responses to several questions, it was reported that only 8 of the 48 responding States (about one in six) reported receiving information on how the Regional Office would monitor and evaluate their implementation of the new guidelines.

Responses of HCFA Regional Offices to Question 1 of E-mail Questionnaire[6]

In addition to the questions asked of State agencies, we provided our Regional Offices an opportunity to report on their efforts to guide State agencies in implementing the new complaint policies. Regional Offices were contacted via e-mail and were given 3 days to respond. We asked each Regional Office to identify the staff person or people who contacted the State agencies, the method of communication (e.g. phone, teleconference), the names of the individuals from each State with whom they spoke, the content of the discussions , and the dates of communication.

The Regional Offices reported giving appropriate notification of the new guidelines, including guidance on implementing the new procedures to their State agencies. Most of this notification was given through conference calls, meetings and telephone conversations. The Regional Offices stated that they did not document their efforts since this was part of their day-to-day business. However, the disparity between the State agencies' understanding of the guidance that was transmitted and the Regional Offices' understanding of that guidance indicates the need to develop a more formal structure of communication between the State agencies and the Regional Offices.

With regard to the directives in the October 13, 1999 letter, some Regional Offices evaluated the process and plan to share their evaluation with other Regions in order to develop a standard evaluation protocol for use in all Regions. Once they have been reviewed by the Regional Offices, these "best practices" will be shared with the State agencies.

[6] The data for this section *(Responses of HCFA Regional Offices to Question 1 of E-mail Questionnaire)* were collected and summarized by HCFA staff in the Center for Medicaid and State Operations (CMSO). CMSO staff wrote this section.

SA Staff Qualifications for Triage and Intake (Questions 2. -3.)

With only one exception, all State agencies responding to this question have established qualifications for staff responsible for assessment and triage of complaints. The following qualifications, or combinations of these qualifications, are expected by most States: a college degree, diploma in a health-related field, work experience in a health care setting, or one year of experience as a qualified surveyor. Fewer State agencies responded about whether they had similar qualifications for staff who did initial complaint intake; however, 14 of the 23 States responding (61 percent) did have at least one of the requirements listed (i.e., college degree, diploma in a health-related field, work experience in a health care setting, etc.) This e-mail survey was abbreviated and, as a consequence, equally important questions such as the nature of staff training programs, State agencies' procedures for assisting with triage or intake, and methods that State agencies use to monitor their own performance, were not explored. Further research will explore these areas in greater detail in their forthcoming telephone survey of the State agencies.

Prioritizing Investigations (Questions 4. -7.)

Every State that responded to the questionnaire indicated that they accept complaints either face-to-face or by telephone. Fifteen States (30 percent) indicated they could not meet the 2-day investigation requirement for immediate jeopardy. Thirteen States (28 percent) reported they could meet the 10-day investigation requirement for actual harm complaints. A majority of responding States (62 percent) did not include weekends or holidays as part of the definition of "within the 2 –working days." States cited staffing shortages, unfilled staff vacancies, increased numbers of complaints, and competition with other workload requirements (e.g., statutory requirement for annual surveys) as the primary roadblocks to meeting complaint investigation timelines. The majority of States reported that immediate jeopardy (IJ) complaints make up less than 5 percent of their complaint workload.

Almost half the State agencies responding (48 percent) indicated that they have developed their own materials to clarify and handle IJ complaints. Forty-two percent of responding State agencies have developed criteria for distinguishing between "higher" and "lower" levels of actual harm.

Most responding State survey agencies used traditional sources of information to help them prioritize complaints (e.g., facility compliance history, complaint history and ombudsman reports). Fewer States were using the Facility Quality Indicator Profile reports that are abstracted from MDS data.

Complaint Workload (Questions 8. -9.)

A majority of States that responded to the survey (34 States, or 71 percent) reported that they believed the volume of complaints has increased since October 1999. However, 31 States (65 percent) indicated that the level of seriousness of complaints was about the same as it had been in the past.

State Survey Agency Complaint Tracking Systems (Questions 10. -12.)

Thirty-eight (79 percent) of the 48 States responding had an electronic or manual complaint tracking system that allows for reporting of immediate jeopardy complaints. However, only 32 States responding (67 percent) had a system to track complaints related to allegations of actual harm. The design of these questions did not allow us to determine how many States have electronic versus manual systems; however, CHSRA intends to address this issue during its forthcoming telephone survey. Thirty-one State agencies indicated that they currently have tracking systems that could report the number of complaints as well as distinguish between immediate jeopardy complaints and complaints of actual harm. Fourteen of these 31 State agencies reported that their systems have only developed the capability to distinguish between types of complaints since October 1999.

Chapter Two - Measures of Problem Identification

The survey process is designed to ensure that nursing homes meet Federal health and safety requirements. In its reports, the GAO (GAO 1998 and 1999) asserted that, despite changes in the survey and enforcement process, the survey process fails in many cases to identify serious problems with quality of care. The intention of the Nursing Home Initiative is to address many of the weaknesses in the survey process identified by the GAO. This chapter looks at several measures of the survey process and reports on whether or not there have been observable changes in these measures since the implementation of the Nursing Home Initiative.

This chapter is a follow-up to certain results published in our July 1998 Report to Congress on survey and certification. Chapter 19 of that report examined evidence of surveyors' success in finding problems during nursing homes surveys. Among other evidence, the report looked at the proportion of nursing homes found to be providing substandard quality of care. The report concluded that States vary greatly in their "ability or willingness to find serious problems and that, in general, States labeled fewer facilities as substandard after implementation of the enforcement regulation than would have been labeled so before the enforcement regulation was put in place (pp. 542-543)." There was evidence, at the same time, of a very slight increase in quality of care in nursing homes. Improvement relative to the period of time before the implementation of new survey and certification enforcement regulations, was observed in rates of bladder and bowel incontinence. It was not clear, however, that improvements in quality of care were great enough to be the sole cause of the decline in substandard quality of care citations.

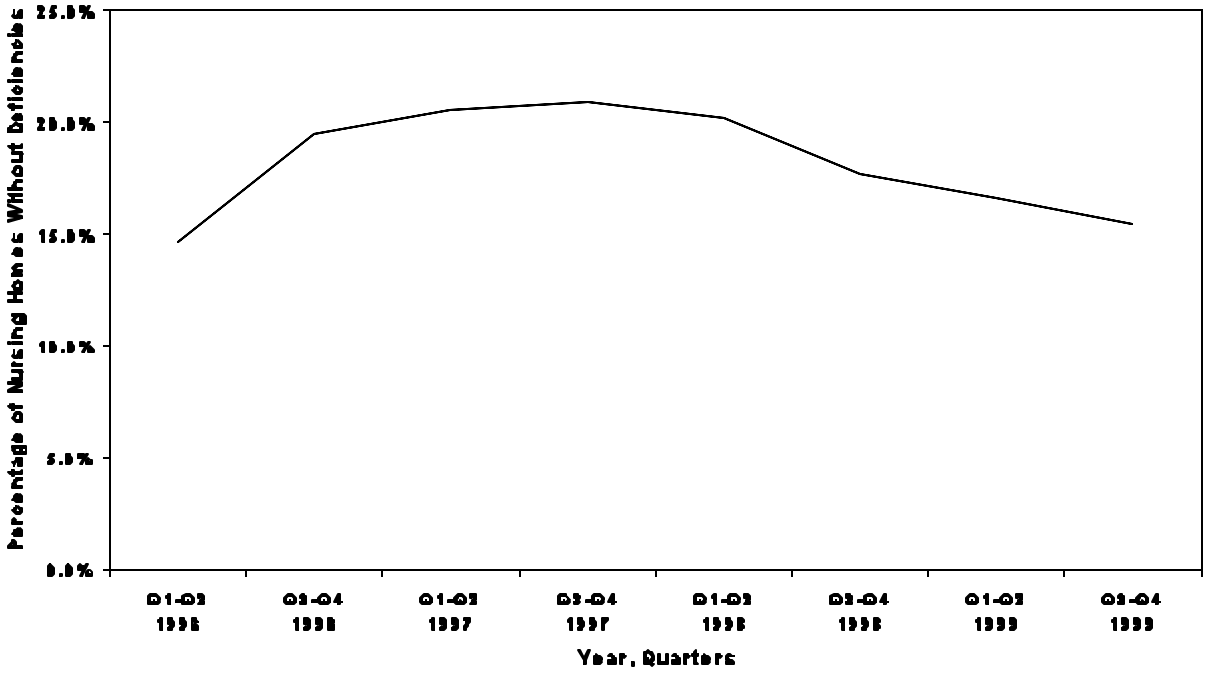
This chapter reports on several measures of problem identification and compares them with earlier results reported in the 1998 Report to Congress. We identified the overall number of deficiency citations and the number of deficiency-free surveys as baseline measures of the effectiveness of the NHI and the quality of nursing home care, because these are commonly used measures of the accuracy of State quality assurance programs. Significant variation in State deficiency citations from the national average number of deficiencies cited or median frequency of such citations (including the absence of deficiency citations) may indicate problems with the State survey process. In addition, to the extent that the overall number of deficiencies cited in any particular State are consistent with the national average or median, we can be more confident that State survey citations may be a more accurate reflection of actual nursing home quality. For this analysis, we used OSCAR data on all nursing home surveys conducted in calendar years 1994 through 1999. Because of the large interstate variation in survey findings, detailed tables are presented in Appendix D.

2.1 Number of Deficiencies and Percent of Facilities with no Deficiencies

Reversing a multi-year downward trend in the average number of deficiencies cited per survey, the national average began to increase in 1998, and has continued to increase, though the mean has not yet increased to pre-July 1995 levels, and it remains to be seen whether the trend will continue. As can be

seen in Figure 2 and Table 3 (see also Tables D-1 and D-2 in Appendix D for more detailed tables), there are two different components of this trend. The first component, the proportion of nursing homes found to have deficiencies, began to increase in 1998, reversing a downward trend that began in early 1995. The second component, the mean number of deficiencies found in nursing homes that have deficiencies, also began to increase in mid-1998. This trend holds for many, but not all, States.

Figure 2. Percentage of U.S. Nursing Homes with Zero Health Deficiencies, 1996-1999



While there could be many possible explanations for this increasing trend in the mean number of deficiencies cited per survey (e.g., changes in facility quality, changes in resident acuity that appear to be changes in facility quality, changes in State survey agency practice, or random variation), we believe it is likely that the increased attention and funding on the survey process, as well as heightened oversight of the States, have been important factors. Data from calendar year 2000 will need to be examined to confirm this observation.

There are a number of activities we have already undertaken to increase consistency of survey findings. We have already instructed State survey agencies to review care records more closely when picking a resident sample, and we instructed States to increase the sample size for certain areas such as pressure

sores. In instances where federal surveyors conduct comparative surveys, we have instructed them to do so closer to the time of the original State survey.

There are also a number of initiatives we have planned that we hope will address State variation. They include the continuation of cross-Regional surveys in which federal surveyors from different Regions accompany other surveyors on surveys in different States, requiring continuing education and periodic recertification of surveyors, and considering options to vary the mix of federal oversight surveys (observational and comparative) to review State surveyor effectiveness. We also have a contract that will advise us on how to further define each level of the deficiency scores in the scope and severity matrix (which is the grid that surveyors use to classify deficiencies-- page 7.)

In addition, our State Performance Standards will go into effect on October 1, 2000. These standards will provide a consistent basis for evaluating and comparing performance across States. As we move forward, and as more data becomes available, we will consider modifying these standards to include other performance measures. Finally, we have directed our 10 Regional Offices to periodically prepare 18 "tracking" reports on areas that measure both State and Regional Office performance. Some examples of these reports include pending nursing home terminations, OSCAR data entry timeliness, and tallies of state surveys that find nursing homes deficiency-free. These reports should enable comparisons within and across Regions and States, and will serve as a management tool for HCFA to identify potential performance problems.

Table 3. Mean Number of Citations Received by Nursing Homes with Health Deficiencies, by Calendar Year[1, 2]			
Year, Quarters		Mean no. health deficiencies	Number of facilities
1994	Q1-Q2	8.3	6063
	Q3-Q4	8.4	6200
1995	Q1-Q2	7.6	6369
	Q3-Q4	7.3	5681
1996	Q1-Q2	6.6	5550
	Q3-Q4	6.1	5661
1997	Q1-Q2	6.3	6303
	Q3-Q4	6.2	6076
1998	Q1-Q2	6.2	6471
	Q3-Q4	6.2	6532
1999	Q1-Q2	6.7	6784
	Q3-Q4	7.0	6037

[1] Source: OSCAR
[2] Excludes facilities with zero health deficiencies

2.2 Citations for Substandard Quality of Care, Pressure Ulcers (Sores), Restraints, and Abuse

This section looks at four measures related to several of the nursing home initiatives, including the number of citations for substandard quality of care, pressure sores, physical restraints, and the prevention and presence of abuse and neglect in nursing homes. The purpose of this section is to report on whether or not there were changes in the rate of citation for these measures for periods before and after the NHI was implemented, and not to demonstrate whether the policies themselves caused these changes. The evidence thus far suggests that there has been an increase in enforcement since the NHI was launched.

Substandard Quality of Care

The term "substandard quality of care" indicates that a nursing home has committed a serious violation of a regulation in one of three areas of care: Quality of Life, Quality of Care, or Resident Behavior and Facility Practices. This designation brings about a number of serious consequences for a nursing home, including the loss of the authority to train nurse aides. State survey agencies understandably use this enforcement option cautiously, except in cases where required by law (when a nursing home has findings of substandard quality of care on three consecutive standard surveys).

In the July 1998 Report to Congress, we selected the proportion of substandard quality of care citations as a rough measure of the propensity to cite deficiencies once problems are identified. These measures of enforcement were found to be associated with poor resident outcomes. The proportion of nursing homes found to be providing substandard quality of care decreased after implementation of the enforcement regulation in July 1995. Since that point, there has been a slight increase in the proportion of nursing homes cited for substandard quality of care. Figure 3 and Table 4 show that the percentage of facilities labeled substandard increased from about 4 percent in 1996 to about 5 percent in 1999. Furthermore, much of this increase has occurred in States with historically (implausibly) low rates of substandard quality of care citations. In the second half of 1996, 11 States had cited no homes for substandard quality of care, and in the second half of 1999, only 6 had cited no homes for substandard quality of care (see Table D-3, in Appendix D, for State level data).

The increases in the proportion of nursing homes cited for substandard quality of care in States with historically low levels of substandard quality of care citations could be due to random variation, but is suggestive of an increase in enforcement action in those States.

Pressure Ulcers (Sores)

Pressure ulcers can develop as a result of unrelieved pressure resulting in damage of underlying tissue. Risk factors for developing pressure sores include poor nutrition, incontinence, inability to move around, and sensory perception deficits. As seen in Figure 3, Table 4, and Table D-3 (see Appendix D), the percentage of nursing homes cited for failing to prevent or properly treat pressure sores increased from about 16 percent in 1996 to about 18 percent in 1999. At the same time, the percentage of residents with pressure sores remained roughly constant. One possible explanation for this result is that the surveyors are identifying these deficiencies more accurately. However, at the State level, this number varies greatly from one time period to another, so it is difficult to conclude whether or not this reflects a real change in surveyor practice.

Table 4. Percentage of Nursing Homes Cited for Substandard Quality of Care, Pressure Sores,\ Improper Restraint Use, and Abuse by Calendar Year.

Citations	1996		1997		1998		1999	
	Q1-Q2*	Q3-Q4*	Q1-Q2*	Q3-Q4*	Q1-Q2*	Q3-Q4*	Q1-Q2*	Q3-Q4*
Facilities Cited for Substandard Quality of Care	4.1	3.8	4.5	4.1	4.5	6.3	5.0	5.0
Facilities Cited for Abuse	6.7	6.5	7.1	7.5	8.3	10.1	10.4	14.1
Facilities Cited for Restraint Use	14.4	13.9	14.5	12.5	12.9	13.0	12.4	9.9

Facilities Cited for Pressure Sores	16.0	14.3	16.4	16.1	17.0	17.9	18.2	17.7
Number of Facilities	9047	8231	8803	8239	8102	7926	8133	7133
Source: OSCAR * Quarters 1 and 2 (January 1 through June 30) ** Quarters 3 and 4 (July 1 trough December 31)								

Physical Restraints

The use of physical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms, is a violation of Federal regulations (42 CFR 483.13(a)). As indicated by figure 3 and Table 4, the percentage of facilities cited for improper use of physical restraints has also decreased slightly in the period examined in this report. This decrease in the citation rate may well be explained by the large, and continued, decrease in the reported rate of restraint use. State level data for this measure are located in Table D-3 (see Appendix D).

Abuse

Prevention of abuse and neglect of nursing home residents is one of the Federal Government's most important roles. Investigation of systems to prevent resident abuse and neglect are an important part of the Nursing Home Initiative. In July 1999, HCFA issued changes to the nursing home survey process, including a significant increase in the use of survey resources to investigate each facility's system to prevent abuse and neglect. A new survey task, a new regulatory tag, and interpretive guidelines, direct surveyors to evaluate the following key components that are required by regulation to be part of the system:

- Screening potential employees for a history of abuse;
- Training employees in handling catastrophic violent reactions of residents and in handling their own frustrations before they escalate into violence;
- Prevention efforts including care planning for residents who are aggressive, deploying enough staff to prevent neglect of care, and controlling the environment to be more secure from outside intrusion (e.g., locking doors at night, etc.);
- Identification of suspicious occurrences or injuries to residents;
- Investigation of suspicious incidents and complaints from residents;
- Protection of residents from harm during investigations; and,
- Reporting alleged violations and substantiated incidents to State authorities.

As seen in Figure 3 and Table 4, there has been a notable increase in the percentage of nursing homes cited for abuse. This trend predates the NHI, but the rate of citation for abuse increased markedly

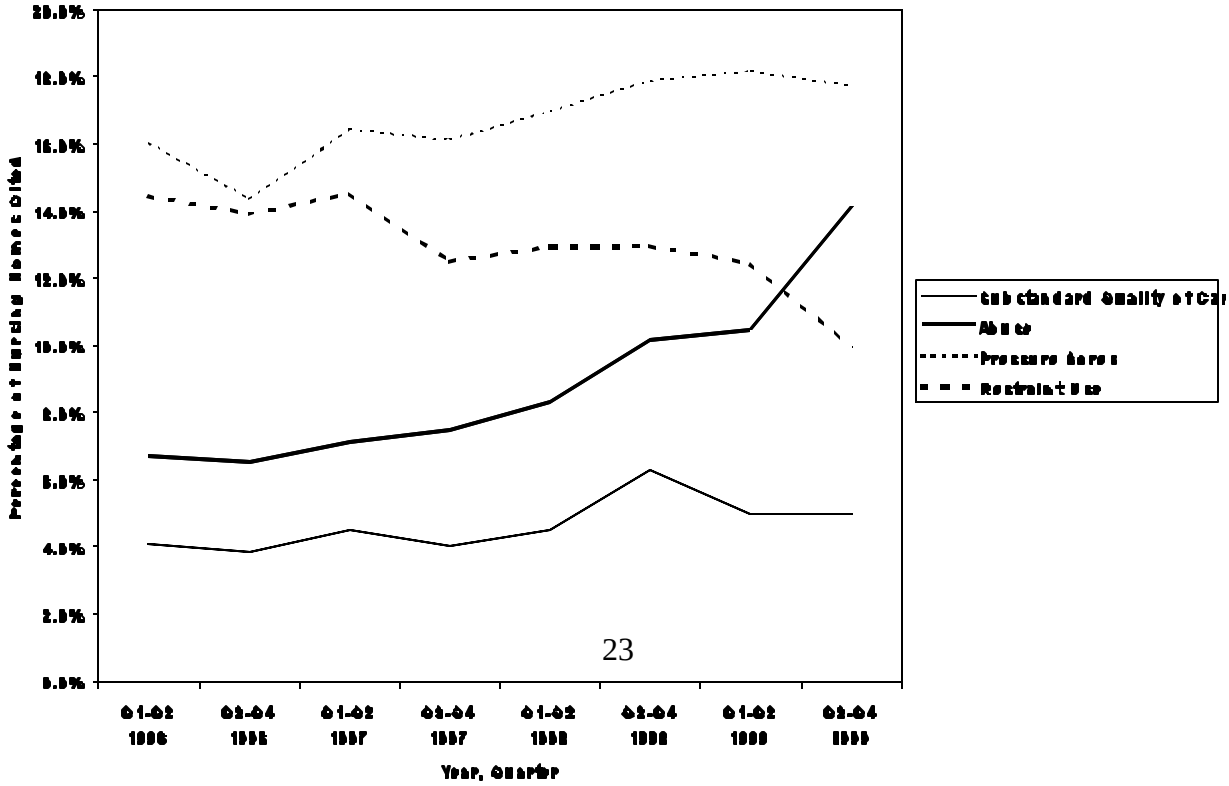
beginning in early 1999. This trend has occurred in most, but not all, States (see Table D-3 in Appendix D).

There are a number of potential explanations for this increase in citation of abuse tags. One explanation is that nursing homes are actually committing more instances of abuse. Another explanation is that surveyors are simply scrutinizing nursing homes more closely in an effort to detect abuse. Another likely explanation is that, under these new protocols, the survey team is directed to cite a deficiency if the facility has failed to satisfactorily implement one or more of these key components, even in the absence of substantiated abuse. This represents an important change from previous policy, under which surveyors preliminarily issued deficiency citations only when documented cases of abuse were discovered. It is quite likely that this increased survey attention to nursing home policies and procedures for preventing and reporting abuse has resulted in an increase in deficiencies.

Discussion

As with variations in pressure sores, there is no definitive explanation as to whether low numbers of deficiencies are attributable to exemplary care or less rigorous survey standards. We are currently working on a multi-tiered plan to improve consistency and accountability in the survey process. This effort includes improvements in training, measurement tools, evaluation techniques, and data. As we strive for more consistency and accountability in the process, there may be better information that could explain these differentials.

Figure 8. Percentage of U.S. Nursing Homes Cited for Substandard Quality of Care, Abuse, Pressure Sores and Restraint Use, 1996-2000



In addition, we annually conduct a minimum of two comparative surveys in each State with the remaining oversight surveys being observational surveys. Comparative surveys are much more labor intensive than the Federal Oversight of State Surveys (FOSS), but they are also more revealing and could help us to gain a better understanding of why some States appear to cite more deficiencies than others. Due to limited resources, the 5 percent Federal Monitoring Survey (FMS) goal is met by a combination of both types of surveys. We are investigating various combinations of these two methods of oversight to determine the ideal number and ratio of comparative surveys to observational surveys. Such a number or ratio, once established and implemented, will eliminate or standardize cross-Regional variation in the number of surveys performed.

Chapter Three - Changes in Resident Characteristics

Several resident characteristics that are most closely related to the interventions of the Nursing Home Initiative, and for which data are readily available, were selected for study to determine if there have been changes over time. The five resident characteristics are the prevalence of pressure sores, tube feeding, physical restraint use, dehydration and weight loss. These resident characteristics, in the aggregate, provide some indication of the disease burden in nursing homes and may provide some measure of how resident status has changed over time. Some of them--particularly the percentage of residents with restraints and who are being tube fed-- are indirect measures of quality of care. These characteristics are affected for example, by the types of residents a nursing home admits. They are also affected by a nursing home's willingness to hospitalize its residents. Based on data through 1999, there has been minimal change in the prevalence of these characteristics, except for physical restraint use. There has been a significant decline in restraint use since 1996.

We identified improper use of physical restraints and the prevalence of pressure sores because these are three of the 24 quality indicators developed by the Center for Health Systems Research and Analysis (CHSRA), and incorporated by HCFA into the survey process. CHSRA developed these quality indicators through a systematic process of interdisciplinary clinical input, and empirical and field testing. These three quality indicators were selected because HCFA has provided extensive guidance to providers about how to prevent improper use of restraints and tube feeding, and how to prevent bed sores. HCFA has also provided guidance to surveyors about how to detect problems in these areas. The presence or absence of potential problems in these areas allow providers to implement needed quality improvement programs and surveyors to direct their attention to examining the quality of care in specific areas.

Methods

We used two sources of data for this analysis. The first source was the OSCAR database, which is HCFA's survey and certification database. The resident data collected in OSCAR are reported by the nursing home at the time of the recertification survey. The data are collected in the aggregate. That is, the nursing home reports the total number of residents with a certain characteristic who are in the facility (or who are away from the facility for a short time) at the time of the survey. For this analysis, we looked at three resident characteristics taken from OSCAR: the percent of residents in physical restraints, the percent of residents who receive enteral feedings (tube feedings), and the percent of residents with pressure ulcers. We looked at data from surveys conducted at several points in time. We compared only nursing homes that were not hospital-based and that had fewer than 25 percent of their residents receiving Medicare SNF benefits at the time of the survey.

The other source of data was the MDS, which contains resident-specific data collected for residents of nursing homes participating in Medicare and Medicaid. It is collected regularly and allows the

comparison of changes in resident characteristics over time. Like the data in OSCAR, the MDS is reported by the facility. The MDS is also used for calculation of Medicare SNF payments and, in a number of States, for the calculation of Medicaid payments. MDS data are also used to generate quality indicators, which are essentially measures of the number of residents with certain characteristics at various points in time.

We take very seriously matters concerning the accuracy of MDS information, given its uses for the development of care plans, for quality monitoring, payment, consumer and provider feedback, policy development, and research. We have dedicated significant resources, and have sponsored a variety of projects, aimed at monitoring and ensuring the accuracy of MDS information. Evaluations have been conducted on the reliability of the instrument (Morris et al., 1990, Hawes, et al., 1995, Morris et al., 1997). Upon implementation of the MDS, State surveyors' tasks were expanded to include the review of a sample of MDS assessments, to ensure that they adequately reflect the resident's condition.

In April 2000, we implemented enhancements to the standard MDS system, designed to improve accuracy of MDS information. These include tightening of edits, causing rejection (for correction and retransmission) of MDS records submitted to the State that contain invalid data, and a new mechanism enabling facilities to make corrections to MDS data that exists in the State MDS databases. In addition, MDS forms have been revised to include a formal statement attesting to the accuracy of the information as completed by individual assessors. The revised forms were implemented September 1, 2000.

We also have sponsored a project to develop on-site and off-site protocols that can be used for auditing the accuracy of MDS information, to provide cost estimates of implementing each protocol, and to offer guidance on who is best suited to implement the protocols. Such protocols should enhance the time- and cost-effectiveness of accuracy monitoring by enabling surveyors or other auditors to target facilities, particular assessments within facilities, or particular sections of assessments where accuracy is suspect. The results of this study also will provide information regarding MDS elements that may be more prone to error, and enable us to focus our on-going efforts to improve accuracy, such as publishing questions and answers and training materials, and clarifying MDS coding instructions.

For this analysis, we used five MDS quality indicators: prevalence of pressure sores, weight loss, tube feeding, dehydration and restraint use in nursing. Because the MDS data are collected for each person, they allow more adjustment for individual risk. The prevalence of pressure sores is therefore calculated separately for residents who are considered (because of the presence of other health conditions) to be at greatest risk of developing pressure sores, and for residents considered to be at comparatively lower risk of developing pressure sores. We also present an aggregate rate for all residents considered together. Because of the of time available for the analysis, we did not exclude hospital-based facilities or facilities with high numbers of Medicare residents from the MDS analysis. Because the calculation of

the quality indicators includes only MDS assessments made at least 90 days after admission[7], most short-term residents are excluded from the MDS Quality Indicator calculations. By contrast, prevalence numbers derived from OSCAR include all persons who were residents in the facility at the time of the survey. Short-term residents, many of whom have recently been admitted from the hospital and who may be more clinically unstable than longer-term residents, may look clinically quite different than longer-term residents. Therefore, although we eliminated nursing homes with high percentages (i.e., greater than 25 percent of the total resident population) of residents for whom Medicare was the principal payor of the nursing home stay, measurements derived from OSCAR and from the MDS Quality Indicators may not be strictly comparable for many types of measurements.

Table 5. Prevalence of Pressure Sores, Weight Loss, Tube Feeding, Dehydration and Restraint Use Among Nursing Home Residents, by Calendar Year[1]

Date of Most Recent Assessment	Number of Facilities	Prevalence of Pressure Sores (%)			Prevalence of Weight Loss (%)	Prevalence of Tube Feeding (%)	Prevalence of Dehydration (%)	Prevalence of Restraint Use (%)
		Low Risk	High Risk	All Risk Groups				
12/01/1998	16865	3.7	16.7	11.0	12.3	8.1	1.7	10.9
06/01/1999	17409	3.9	16.8	11.1	13.0	8.1	1.8	10.5
12/01/1999	17280	3.5	16.0	10.5	11.9	8.1	1.3	10.3

[1]Analysis of MDS Quality Indicators by Iowa Foundation for Medical Care

Table 6. Prevalence of Restraint Use, Tube Feeding and Pressure Sores in Nursing Homes, by Calendar Year[1]

Prevalence %	1996		1997		1998		1999	
	Q1-Q2	Q3-Q4	Q1-Q2	Q3-Q4	Q1-Q2	Q3-Q4	Q1-Q2	Q3-Q4
Restraint use	18.7	17.3	16.3	14.7	13.6	12.9	12.3	11.1
Tube feeding	6.0	6.1	6.2	6.3	6.5	6.6	6.8	6.6
Pressure sores	6.2	6.2	6.4	6.1	6.4	6.3	6.4	6.3
Number of facilities	7988	7276	7695	7217	7179	7004	7257	6327

[1]Source: OSCAR excludes hospital-based nursing homes and any nursing home with greater than 25% of its residents receiving Medicare, but not Medicaid, SNF benefits at the time of the survey.

Results

[7] Admission assessments are not considered in the calculation of the quality indicators. Residents who are discharged before two follow-up assessments are completed will not be included in the calculation of the quality indicators.

This section presents the results for the five other characteristics examined.

3.1 Pressure Sores:

Rates of pressure sore development are a widely-cited measure of the quality of health care (Rudman, Mattson et al. 1993; Berlowitz, Ash et al. 1996; Mukamel 1997; Ooi, Morris et al. 1999; Berlowitz, Bezerra et al. 2000). Comparison of the frequency of existing pressure sores is a more problematic measure of quality of care, because health care facilities–nursing homes in particular–differ widely in the characteristics of the patients they admit. Some nursing homes, for example, admit many patients with existing pressure sores. It is also more difficult to associate the prevalence of pressure sores with process measures of quality. However, the prevalence of pressure sores in the aggregate does give an indication of the overall status of nursing home residents and provides a useful comparison over time. For this report, we are presenting data on the prevalence of pressure sores for all States.

Prevalence data come from OSCAR and from the MDS. Data collected by OSCAR are reported by the nursing home at the time of the survey and represent a snapshot of the facility at the time of the survey. OSCAR data are collected in the aggregate. It is thus not possible to know how many residents have multiple medical conditions. In order to make the data more comparable from one State to another, OSCAR comparisons were made only for nursing homes that were not hospital- based and that reported that fewer than 25 percent of its residents were on a Medicare stay. Data suggest that residents in nursing homes that are hospital-based or that have large volumes of Medicare patients, have a much higher rate of pressures sores on admission than do residents of other nursing homes (Mor, 2000).

Prevalence, as used in this context, indicates the percentage of nursing home residents with a particular condition. Table 5 (see also Table D-9) presents data from the MDS on the prevalence of pressures sores during three 6-month time periods, beginning with the earliest period for which data are available. Because MDS data are collected at the individual resident level, it is possible to group the data so that residents who are at approximately comparable risk of developing pressures sores are grouped together. Thus, the table presents data on the prevalence of pressure sores among nursing home residents who are considered to be at low risk, at high risk, and for both sets of residents considered together. The prevalence of pressure sores, as reported by nursing homes on the MDS, and as calculated by the quality indicators, is quite a bit higher than in OSCAR. For all risk groups taken together, the prevalence of pressure sores from the MDS quality indicators is about 11.0 percent for the three time periods considered. In OSCAR, the prevalence of pressure sores ranges from 6.0 to 6.8 percent during that period.

Table 6 (see also Tables D-4 and D-6 in Appendix D), which presents data from OSCAR, shows that the prevalence of pressures sores has changed little from 1996 to 1999, varying from 6.1 to 6.4 percent during this period. Table 6 shows that considerable State-to-State variation persists. State averages

range from slightly above 3 percent for several States in the Midwest, to above 10 percent. The rates vary somewhat from period to period, but, at this point, there is no strong evidence of a trend over time.

Table D-6 presents data from OSCAR grouped to show the percentage of facilities in each State that fall into prevalence categories. In other words, this table shows the percentage of facilities in each State that have zero residents with pressure sores, that have 1-10 percent of residents with pressure sores, etc. As in the previous table, no trend over time is evident. However, this table suggests that there is also considerable variation from one State to another in the percentage of facilities whose residents have no pressure sores. Even among States with more than 200 nursing homes, the percentage of nursing homes with no residents with pressure ulcers ranged, in the latter half of 1999, from 2 to 23 percent.

A map of the prevalence of pressure sores by State, (on page E-1 in Appendix E), underscores the apparent variation that exists across States. This map also shows that the reported rates vary by Region. New England and the North Central States report much lower rates of pressure sores than do nursing homes in other parts of the country. We cannot reach any definitive conclusions from these data about the cause of these variations. However, possible explanations include different reporting practices, differences in case-mix, differences in rates of transfer of residents from nursing homes to hospitals, differences in surveyor documentation, or true differences in quality of care.

3.2 Tube Feeding

Estimates suggest that, across the nation as a whole, an increasing number of elderly persons are receiving gastrostomy tubes (Grant, Rudberg et al. 1998). This is a practice for which the clinical value is controversial (Grant, Rudberg et al. 1998; Gillick 2000). It is often used in residents with advanced dementia who suffer from aphagia. For this analysis we used data from OSCAR and MDS about the presence of tubes used for feeding. These include, among others, naso-gastric tubes, gastrostomy tubes, jejunostomy, and percutaneous endoscopic gastrostomy (PEG) tubes.

Both data from OSCAR (presented in tables 6, D-4, D-7) and from the MDS (Tables 5 and D-8) suggest that in some States, though not in all, there is evidence of an upward trend in the prevalence of tube feeding. In the first half of 1996, facilities in OSCAR reported that, on average 6.0 percent of residents were being tube fed. By the first half of 1998, that number had climbed to 6.5 percent, where it has remained.

In addition, both OSCAR and the MDS suggest enormous variation from State-to-State in the use of feeding tubes, with rates ranging from about 2 percent to over 15 percent in 1999. This variation might reflect differences in practice patterns, but may also reflect some differences in case-mix. It is also possible that some or all of this variation may be due to differences in reporting.

State-to-State differences are highlighted on the map on page E-2 (Appendix E). As with the prevalence of pressure ulcers, there also appears to be Regional clustering, with States in the North Central portion of the U.S. reporting the lowest rates of tube feeding.

3.3 Physical Restraint Use

Data from both OSCAR (Figure 4 and Tables 6, D-4, D-5) and from the MDS (Tables 5 and D-8) show that the use of physical restraints has declined markedly over time in almost every State in the country. It is clear that the decrease in the use of physical restraints preceded the Nursing Home Initiative. Indeed, a number of regulatory and nursing home industry initiatives over the last few years have been aimed at reducing the use of physical restraints. However, the good news appears to be that the use of restraints continues to decline. In fact, States such as California, Massachusetts, and Indiana, with apparently high proportions of nursing homes that relied heavily on the use of physical restraints in 1996, have shown marked decreases in the last 2 years in the proportion of high-restraint-use facilities. For example, in the first half of 1996, almost 49 percent of nursing homes in California reported that more than one-quarter of their residents were physically restrained. By the second half of 1999, the proportion reporting that more than one-quarter of their residents were physically restrained had dropped to 26 percent. At the same time, the proportion of restraint-free facilities in these States has also increased. In the first half of 1996 5.7 percent of facilities in California reported that they were restraint free. By the second half of 1999, however, 10 percent of facilities in California were reporting that they were restraint free.

Map E-3, in Appendix E, shows the prevalence of physical restraints in 1999, by State. As with pressures sores and tube feeding, it is apparent that large inter-State variations exist. Again, North Central States report the lowest average rates of physical restraint use.

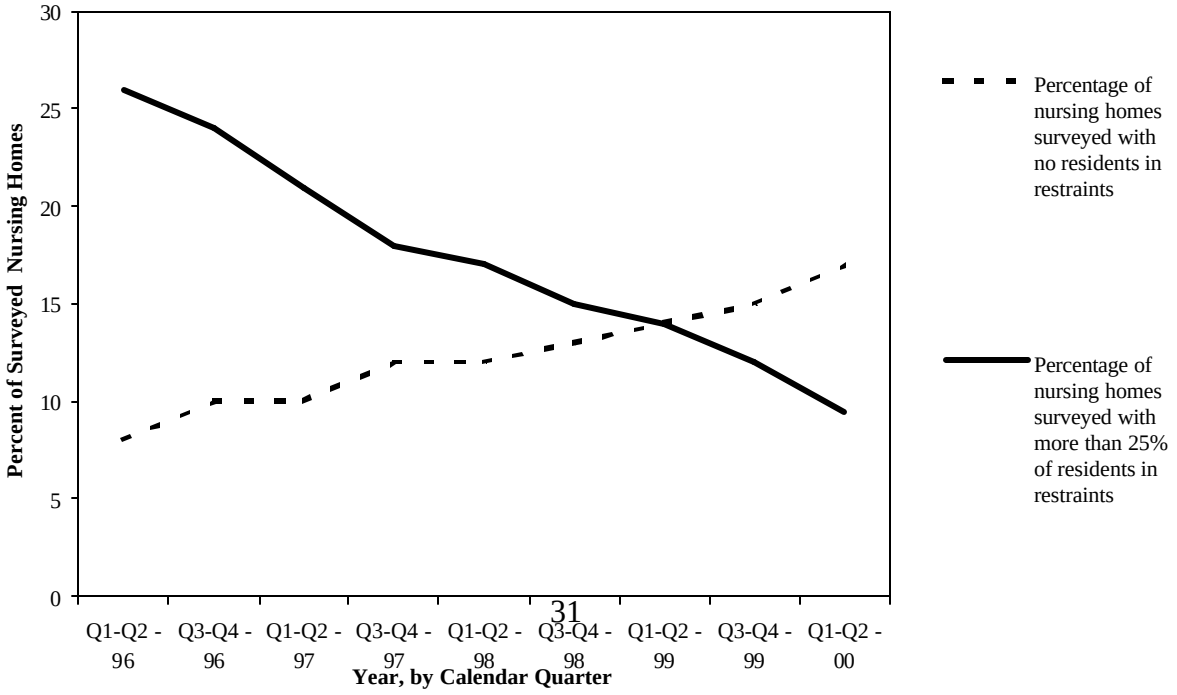
3.4 Dehydration

Dehydration is an often-cited quality of care problem in nursing homes (Fries, Hawes et al. 1997). In addition, dehydration is an important risk factor for a number of other serious health conditions. Dehydration is, however, a resident condition that may be difficult to ascertain without careful monitoring of an individual's fluid consumption and output. Dehydration is also a condition that may be confounded by a person's nearness to death, because the process of dehydration may occur during the process of dying. There is also evidence to suggest that an increasing proportion of persons are leaving hospitals to die in nursing homes, so that an increase in apparent rates of dehydration in nursing homes may not necessarily reflect poor care (Teno2000). It is therefore reasonable to be particularly cautious in interpreting the facility self-reported data in the MDS. Nevertheless, overall prevalence of dehydration reported in the MDS (Tables 5 and D-8) is low, averaging just under 2 percent. There is no evidence in these data of a change in prevalence of dehydration over time.

3.5 Weight Loss

Unexplained weight loss is a risk factor for disability and death and may be an indicator of undernutrition (Cumming and Klineberg 1994; Ryan, Bryant et al. 1995; Spector and Fortinsky 1998; Yaari and Goldbourt 1998; Reynolds, Fredman et al. 1999). Weight loss may, however, also occur in terminal stages of disease. Tables 5 and D-8 suggest that there has been no observable change in weight loss prevalence during the period of this report.

Figure 4. Restraint Use In Nursing Homes, 1996 - 2000



Tables 5 and D-8 shows the average number of residents per State reported by the nursing homes as experiencing weight loss.[8] The overall prevalence of weight loss in nursing home residents declined slightly, from 12.9 to 11.9 percent, for the 6-month period ending December 1999, compared with the 6-month period ending June 1999. Facilities in 80 percent (40) of the States reported a decline in the prevalence of weight loss.

Efforts to improve Management Information Systems (MDS, OASIS, and OSCAR) will help improve our ability to target potential quality problems based on outcomes and quality measures. For example, MDS Quality Indicator reports are operational and being used by HCFA and survey agencies in the survey process. These reports are available to State and Regional Office surveyors and help guide the surveyors toward potential quality of care problems in nursing homes. Similarly, OASIS Quality Indicators are currently being programmed into the computer systems and will be available to survey agencies by late Fall. These reports will be used to guide surveyors towards potential problems in care provided by the home health agencies. Development of modules for other provider types or subsystems will begin in September.

[8] Weight loss, as defined by the MDS, refers to a loss of body weight greater than 5 percent in the 30 days, or more than 10 percent in the 180 days, prior to the completion of the resident's MDS assessment.

Chapter 4 -- Consumer Information

HCFA has launched several efforts to help educate consumers about choosing a nursing home. These efforts include the Nursing Home Compare website, and a guide and video on choosing a nursing home. We also have begun educational campaigns about specific problems some nursing home residents encounter-- malnutrition and dehydration, and abuse and neglect. Finally, though not a part of the President's Nursing Home Initiative, HCFA also tested the use of postcards intended to give nursing home residents, their families, and nursing home staff, the opportunity to send in anonymous comments to HCFA.

Nursing Home Compare Website

In 1998, HCFA introduced the Nursing Home Compare website. This award-winning website, at *www.medicare.gov*, allows consumers to search by zip code or by facility name for information on each of the 17,000 nursing homes participating in Medicare and Medicaid. The website also includes data on each facility's care and safety record, staffing levels, number and types of residents, facility ownership, and ratings in comparison to State and national averages. The site is recording 500,000 page views each month and is by far the most popular section of our website.

Once surveys are completed and posted in the Online Survey, Certification and Reporting system (OSCAR), they are loaded onto the Nursing Home Compare website within 1 month (the website is updated at the beginning of each month). We understand that failure to enter data into OSCAR quickly enough could have a negative impact on the usefulness of the website. We reviewed additional OSCAR data and determined that the problem of old surveys on the website may be two-fold: States may not be completing surveys in a timely fashion, and/or may not be entering the data from completed surveys into OSCAR promptly. We identified 15 States in which HCFA has records for fewer than 90 percent of its facilities in fiscal year 1999. We have sent letters to the State Agency Directors of these States asking them to explain the reason for the missing surveys and/or data. We hope that the responses will enable us to isolate the sources of the problem so we can effectively assist States in meeting the new standards.

We will, however, continue to work closely with States to improve the speed with which data are posted in OSCAR. In fact, new State performance standards require that States enter survey data into OSCAR within 20 days of finalization of survey findings.

"A Guide to Choosing a Nursing Home"

In an effort to provide the general public with information about choosing a nursing home, we revised our publication entitled " A Guide to Choosing a Nursing Home." Research was conducted to evaluate the effectiveness of this guide, based upon feedback from family caregivers involved in the decision-making process of placing a family member in a nursing home. The Seniors Research Group, a

contractor to HCFA, conducted four focus groups to help improve the guidebook. The focus groups consisted of individuals who had recently placed a family member in a nursing home or who were considering doing so.

Specifically, the objectives of the research were to:

- Assess whether family members who care for beneficiaries consider the "Guide to Choosing a Nursing Home" to be organized and presented in a way that is easy to understand;
- Determine the helpfulness of the guide in choosing a nursing home; and,
- Obtain suggested enhancements or improvements.

The focus groups provided responses useful to the design of the guidebook. Among the important findings was that most caregivers did not know where to begin in their search for a nursing home and were unaware of the resources available to help them. For example, most participants were unaware of the availability of the guidebook. All inexperienced caregivers who participated in this focus group had never heard the word "ombudsman" until they read it in this guide. Even participants who had already had experience in placing a family member in a nursing home were not aware of the ombudsman program until after they had placed a family member in a nursing home. Additionally, many of the participants in this study were unaware of the existence of discharge planners in hospitals.

Participants reported that they liked the guide overall. Both experienced and inexperienced participants felt the guide would be very helpful for choosing a nursing home. They felt that it would help them organize their thoughts and raise issues that had not been previously considered. Participants liked the layout of the guide. They felt it was very easy to understand and was user-friendly. They noted that the order was very logical and sequential.

However, participants also reported that they felt overwhelmed by the wealth of information in the guide and felt that the target audience of the guide was unclear at times. Some participants noticed that this guide was written to multiple audiences (both caregivers and potential residents) and felt that at times this made the document confusing. All participants agreed that if this guide was to be written to one audience, it should be targeted toward the caregivers, as they are most often the people making the decision. They also noted that potential residents are often incapable of reading this information on their own. They described the most likely scenario for beneficiary involvement is the caregiver reading through the guide with the future resident. Participants mentioned that certain sections in the text, especially crucial steps, were not emphasized and could get lost in the text. This is particularly true for caregivers needing to search quickly for a nursing home, who were most likely to skim through the guide.

This evaluation provided evidence that caregivers, in the process of searching for a nursing home placement, may lack critical information--such as how to evaluate a nursing home and how to use the ombudsman program to help them make a decision. Though flaws exist in the guide, participants in the focus group provided evidence that the guide can be very helpful in the search for a nursing home. We will use the specific comments from the focus groups to revise the guidebook in order to make it even more usable to caregivers.

In addition, we have greatly expanded the distribution of the Guide to Choosing a Nursing Home. This guide is now available through the 1-800-MEDICARE call center, both on an automated ordering line and through the customer service representatives. It has been revised this year and added to a list of available Medicare publications in the Medicare & You 2001 handbook; mailed directly to industry groups and advocates including the National Citizens Coalition on Nursing Home Reform, American Health Care Association, American Association of Retired Persons, the State Health Insurance Assistance Programs, nursing home ombudsmen; and included in a targeted group of publications to be marketed by the Consumer Information Center in Pueblo, Colorado. We are planning another revision in 2001, and will investigate additional distribution channels.

"What to Look for in a Nursing Home - Update 1999." (Video guide)

In an effort to provide the general public with information about choosing a nursing home, HCFA updated an informational video entitled "What to Look for in a Nursing Home - Update 1999." Research was conducted to gather feedback on the quality, content, and use of this video. Hospital-based social workers involved in discharge planning for the elderly, and nursing home professionals such as Regional and long term care ombudsmen, and citizen advocacy groups, were interviewed during the summer of 1999. Assessments were conducted among focus groups of social workers working in two different areas: 1) an area with a limited supply of nursing home beds, and 2) an area with an abundant supply of nursing home beds. Seven hundred advocates and ombudsmen were mailed the videotape. Phone interviews were conducted with 268 (38 percent) of them. Of this group, 152 had both received and viewed the video. In addition, three focus groups were conducted with a subset of the participants in the phone survey.

Professional social workers and discharge planners typically felt that the video was less useful to them than did nursing home consumer advocates and ombudsmen. In general, hospital-based social workers who participated in this study felt that, if the video was revised, it would be helpful as a tool to supplement the social workers' usual one-on-one sessions with clients, but many of the social worker participants felt that this video only skimmed the topic of choosing a nursing home. While the discharge planners who participated in the study saw the video being targeted towards consumers, few thought it had hit the intended audience. Many of the discharge planners reported that the language was geared more toward professionals than families, but that the material in the video was not specific enough to use for training professionals. Both discharge planner and social worker participants liked the last part of the video, which featured Hugh Downs discussing the checklist and mentioning resources such as ombudsmen, the website, and the 1-800 number. They also liked the description of Medicare coverage in this section, although they thought it was too brief.

In general, the response of nursing home advocates and ombudsmen to the video was more positive. Participants thought that the video was of high production quality and well executed. Half felt the video was extremely, or very useful, and half are currently using it. However, like the social workers and

discharge planners, most thought that HCFA was attempting to target consumers with the video, but that the video missed the target audience. This group of professionals, like the social workers, identified the nursing home checklist as the most helpful part of the video.

In summary, both sets of participants, hospital-based professionals who assist in the nursing home search process, and consumer advocates and ombudsmen, felt that the video had strengths. Both felt that the specific information provided in the nursing home checklist was helpful. It appears that both groups felt that the intended audience of the video was unclear, which might muddle its message slightly. HCFA will use the results of these studies to improve future versions of the video.

Nutrition and Hydration Campaign

The prevalence of malnutrition and dehydration in nursing homes is used by many as an indirect measure of quality in nursing homes. The July 1998 HCFA report and GAO reports suggest the prevalence of malnutrition and dehydration is unacceptably high and that abuse of residents continues at alarmingly high levels. Under the Nursing Home Initiative, HCFA has launched the Nutrition and Hydration Campaign, a national program to educate residents, families, consumers, nursing home staff, and the public, about the risks of malnutrition and dehydration.

Under the Nutrition and Hydration Campaign, HCFA helped the Nutrition Screening Initiative (NSI) by focus testing the Nutrition Care Alerts among targeted caregivers. The Nutrition Care Alerts, developed by NSI, are educational tools for caregivers and contain information about warning signs and action steps to prevent unintended weight loss and dehydration among nursing home residents. Testing was done in 20 nursing homes across the country, using one-on-one interviews with Certified Nurse Assistants (CNAs) and other staff.

Respondents reported that the information contained in the Nutrition Care alerts was important, helpful, and interesting. They also reported that they had strong intentions to save the pamphlet and refer back to it. Recommendations by the target audience have been used to create the most user-friendly versions of the educational tool (pocket guides, bookmarks, and one-page flyers) in order to maximize their use.

The testing was not intended to evaluate the effectiveness of the tool on quality of care, but to determine its usefulness to nursing home caregivers. However, a study concept paper has been received from the American Medical Directors Association (AMDA) which proposes a more precise evaluation of the behavioral and clinical impact of such tools when used in a nursing home setting.

Nursing Home Comment Cards

At the suggestion of a consumer representative, we developed a comment card to collect information about the overall satisfaction of beneficiaries and their families with the care and services they are receiving and to inform nursing home residents and family members of a local toll-free telephone number

available to help with specific instances of concern. Two States, Connecticut and Texas, volunteered to participate in a pilot test of the comment cards. Ombudsmen in Connecticut, in the course of their normal rounds, distributed the countertop displays, and distributed the comment cards to residents. Texas nursing home administrators received the countertop displays and comment cards by mail, along with a letter from the Dallas Regional Office, requesting their participation and asking them to place the countertop display in a visible area. The comment cards were color coded: yellow for countertop displays (to be completed by family members, visitors, volunteers, staff members, clergy, etc); white for residents who could complete them on their own; and green for residents who needed assistance completing the cards. All participation was voluntary. Residents with pervasive confusion did not participate.

The pilot was conducted from December 1999 through March 2000. Respondents returned a total of 2,182 comment cards to us. We reviewed the cards and identified 42 (1.9 percent) which appeared to represent an emergent situation and were immediately referred to the appropriate Regional Office for the State to follow up. Cards from respondents identifying themselves as residents were received from 110 (43 percent) nursing homes in Connecticut and from 20 (2 percent) nursing homes in Texas. In addition, we received a number of comment cards from persons identifying themselves as family members or staff from 120 (47 percent) nursing homes in Connecticut and 256 (20 percent) nursing homes in Texas.

The pilot project suggests that comment cards may provide an alternative way for residents or other persons to notify HCFA of emergent situations. We will continue to work with consumer and industry representatives on this and other innovative ways to help beneficiaries and their families communicate with us and State agencies about their satisfaction with the quality of care they are receiving.

CONCLUSION

This report has looked at the implementation of the Nursing Home Initiative, at measures of problem identification in the survey process, and at resident characteristics.

The report found that many of the policies contained in the NHI have been implemented in most States, though the initiatives that appear to require more complex policy guidance (e.g. changes to the complaint investigation process) appear to be more problematic. As an example, most States are reporting that they have dramatically increased the proportion of surveys they conduct on weekends and evenings. However, many States are reporting that they are having difficulty meeting the shorter timeframes now required for investigating allegations of immediate jeopardy and actual harm. A number of States report that they have received little guidance from us in defining instances of actual harm or in setting up a reporting system. Our Regional Offices felt that they had given adequate guidance. The data do suggest, however, that many States have not yet established complaint investigation protocols suitable to meet the timeframes that we have set.

Compared with findings published in the 1998 Report to Congress on the survey and certification process, States now appear to be finding more deficiencies on average and finding fewer facilities to be deficiency free. However, considerable variation across States in the number and type of deficiencies cited remains. The increase in citations for resident abuse is perhaps the most striking finding. The raw data do not indicate whether this represents a change in State survey agency practice or a change in facility quality. However, reports of an increase in the number of complaints suggest a possible change in nursing home quality, though they also may represent an increased public awareness of nursing home problems.

Finally, data on resident characteristics, while a rough measure, show little change over time, with the exception of a notable downward trend in the use of physical restraints. This is a true success story, but probably reflects ongoing efforts on the part of providers, consumers, and the government, rather than any intervention specific to the Nursing Home Initiative. Notable geographic variation in the rates of many of these characteristics persist. Variations may reflect practice differences, reporting differences, or some combination of the two. Nevertheless, they suggest that influencing these rates will probably require dramatic changes in public and provider acceptance of practice patterns.

Although this report provides a limited assessment of only part of the NHI, we think future assessments can be more comprehensive. First, it may be possible to develop measures of the degree of implementation of the various parts of the NHI and compare outcome measures for States that are relatively high implementors of the NHI to those for low-implementation States. Second, we may be able to take advantage of the varied time of implementation of the PPS and develop a quasi-experimental design for assessing the impact of the PPS and the NHI.

Third, in future reports we may be able to contrast changes in resident characteristics that were targeted by the NHI with other problem areas not targeted. Fourth, conclusions about the effectiveness of the NHI might be arrived at indirectly by eliminating other explanations for changes in apparent quality, such as changes in case-mix. Finally, we may conduct some qualitative case studies on the processes implemented by States that appear to have achieved very good outcomes.

Overall, we are pleased with the improvements and are committed to ensuring that the NHI is fully and effectively implemented. We will continue to analyze actions begun under the NHI, and implement changes as necessary. For example, further examination and analysis are needed on a number of different issues, including the frequency and feasibility of Federal Comparative Surveys and the adequacy of the current range of available sanctions. In addition, we are exploring ways to disseminate more extensive information so that beneficiaries may better understand their long term care options in order to obtain services.

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Appendix A - Survey and Certification Budget Table

Table A. Sources of Nursing Home Initiative funding within HCFA and the Department for the FY 1999 to FY 2001 Period in Millions of Dollars			
Funding Sources	**FY 1999 Actual**	**FY 2000 Approved**	**FY 2001 Request**
HCFA Discretionary			
Survey & Certification	$8.0	$23.4	$29.7
Federal Administration	$0.0	$16.9	$6.1
Research	$0.0	$0.0	$2.0
HCFA Mandatory			
Medicaid Survey & Certification	$0.0	$25.1	$25.7
PRO contracts	$6.2	$4.8	$3.6
Patient Abuse Registry User Fee	$0.0	$0.0	$4.3
General Departmental Management			
Departmental Appeals Board	$1.0	$2.8	$4.5
Office of General Counsel	$0.0	$6.7	$9.0
Total HHS NHI Funding	$15.2	$79.7	$84.9

Appendix B:
State Survey Agency Implementation of the HCFA Complaint Policies-
Summary Report of E-mail Questionnaire Discussion of Results

State Survey Agency Implementation of the HCFA Complaint Policies-Summary Report of E-mail Questionnaire Discussion of Results

This discussion is organized in the order of the questions on the e-mail survey. At the end of some sections, "bulleted" questions/issues/concerns appear; HCFA should consider these based on the responses provided by the State survey agencies. Likewise, CHSRA intends to consider these issues as it completes final construction of the upcoming in-depth telephone survey of all State survey agencies about their complaint processes.

States have been given ID numbers to provide confidentiality of their responses.
In a very few cases (7) a State's answer to a specific question was changed from "Yes" to "No" or vice versa based on narrative comments they provided that clearly contradicted the "Yes or "No" answer checked. Also note that in some cases State survey agencies did not respond to every question and therefore the total number of responses does not add to 48 for all questions.

1a. Did HCFA Regional Office (RO) staff meet with you (in person or by teleconference) regarding the clarification and guiding principles HCFA communicated to you in the October 13, 1999 letter from Rachel Block?

1b. Did the discussion include the manner in which the RO proposed to evaluate the State's implementation of the new complaint investigation guidelines?

Questions 1a. and 1b. asked about HCFA Regional Office involvement in clarifying the complaint investigation guidelines issued in the 10/13/99 letter. Forty-two percent (20) of the State agencies responding indicated that the HCFA Regional staff clarified the guidance either in person or by phone. Twenty-six States indicated HCFA Regional Office staff had not contacted them and two States were unsure.

HCFA Regional Office contacts regarding this complaint guidance varied considerably. Only Region VII – Kansas City had direct contact with all States in the Region regarding the complaint guidance letters. Regions II – New York and IX – San Francisco appear to have had no contact with their States while all other Regions had contact with only some States.

For the States for which there was direct contact, fewer than half (8 States or 40 percent) indicated that they were provided a description of how the Regional Office would evaluate the State's implementation of the complaint investigation guidance provided in the HCFA Central Office letters. This means that only 8 of the 48 States responding to the survey or slightly less than 17 percent of the States reported receiving information on how the HCFA RO would monitor and evaluate their implementation of the new guidelines.

2. What are the minimum qualifications (education and work experience) for SA staff responsible for assessment and triage of complaints? Respond to each question (#2a - #2d) and type in any additional comments you wish to make at the end of this question.

(i) College degree
(ii) Diploma in health-related profession
(iii) Work experience in a health care setting
(iv) Qualified surveyor with one year of experience
Please specify any other qualifications required:

The October 13, 1999 guidance letter addresses the need for determining the priority assignment of complaint allegations for investigation. In order to make priority assignments, HCFA states that "an assessment of each complaint must be made by an individual who is professionally qualified to evaluate the nature of the problem based upon their knowledge of current standards of practice and Federal requirements." In effect, the person who makes these assessments of the nature and severity of the problem reported by the complainant determines how quickly the complaint must be investigated. Since the resident may be in immediate jeopardy, this is a serious task. Question 2 looks at the qualifications States set for the individuals making priority assignments (or "triage") for complaint investigations.

Although the qualifications for individuals conducting assessment and triage varied from State to State, it appears that all States that responded to question 2 have some standard that defines the qualifications. Only one State indicated that it had no formal requirements but that most individuals doing the assessment and triage function had a college degree and some health care experience. Twenty-seven States (64 percent of those responding) indicated that they required a college degree, and 32 States required a diploma in a health-related field (73 percent of those responding). Thirty-two States (78 percent of those responding) require work experience in a health care setting, and 34 States (77 percent of those responding) required that the person doing "triage" be a qualified surveyor with at least 1 year of experience.

At the same time, there was limited overlap in educational and experience requirements. For example, only 13 out of 48 States (or 27 percent) indicated that they required a college degree, a diploma, work experience in a health care setting and qualification as a surveyor with 1 year of experience. An additional six States required a diploma, work experience and qualified surveyor status, but no college degree. Perhaps a more interesting finding is that 10 States specifically indicated that only supervisory staff completed assessment and triage. Table 1 (attached) contains a summary of requirements by State.

3a. Is the staff responsible for the intake of complaints the same staff as those that are responsible for triage?

Seventeen States out of 48 responding (35 percent) indicated that the same staff responsible for assessment and triage was also responsible for intake of complaints. General reasons for this arrangement included small State agency size or rural offices where staff had multiple roles or that the intake staff (usually nurses) were responsible also for the assessment and triage.

State agencies that responded "Yes" to question 3a. were directed to "skip" question 3b. However, some State agencies that responded "Yes" to 3a, still answered question 3b.; their responses were excluded from the tally of responses to question 3b.

3b. What are the basic qualifications for intake staff?

(i) College degree
(ii) Diploma in health-related profession
(iii) Work experience in a health care setting
(iv) Qualified surveyor with one year of experience
(v) Please specify any other qualifications required:

Intake is a critical function, since it is the complainant's first contact with the State survey agency about a particular problem or danger. Moreover, if the person doing complaint intake does not secure accurate and comprehensive information, or does not report it accurately, the person doing triage and assigning complaints for investigation may make a serious error in assessing the seriousness of the complaint. Despite this, States tended to have fewer well-specified criteria or qualifications for intake staff.

Unlike the staff who do the assessment and triage function discussed in question 2 above, fewer States have qualifications for their personnel conducting the complaint intake function. Thirteen of the 34 States (38 percent) that responded to this question indicated that they had no specific qualifications for staff responsible for complaint intake. Some States indicated that, although they have no specific requirements, they prefer staff to have a college degree or a background in health care. One State provides "on the job training," two States indicated that they use support staff, and several others indicated that the background of their intake staff "varies."

Eight States responded that they required a college degree, 16 required a diploma in a health care related field, 13 required work experience in health care and 11 required the use of qualified surveyors with at least 1 year of work experience. Fifteen of the States responding required two or more of the

four possible qualifications options presented in the questionnaire. Table 1 (attached) summarizes the responses to this question.

4. Will you accept verbal (telephone or face to face) complaints?

All 48 States responded that they accept verbal complaints either by telephone or face-to-face. Additional information is needed, however, to evaluate the accessibility of the complaint process, such as:

Is there a toll-free number?
Must facilities post this number in a prominent place?
Does the State monitor this intake line to determine whether the call-load is so high that many people get a continuous "busy" signal?
Are facilities available for intake from persons who are not fluent in English?
Is there a mechanism in place for receipt of complaints at night and on weekends and holidays?
Will the agency accept anonymous complaints?

5. The current guidelines require that allegations that involve "immediate jeopardy" (IJ) be investigated within "2 working days of receipt of the complaint."
5a. Are you having any difficulty meeting this time frame?

Fifteen States reported that they were having trouble meeting the two working days time frame for investigation of complaints involving allegations of immediate jeopardy. Four States indicated that insufficient staffing or funding created timing difficulties for them. Two States commented that it was difficult to determine immediate jeopardy from the intake process. One State mentioned high surveyor staff vacancies as a problem, while two States stated that immediate jeopardy complaints caused reassignment or delay of current open cases and deferral of annual surveys.

For States that answered they were not having a problem (31 States) there were some interesting comments. Two States indicated that they investigate immediate jeopardy complaints within 24 hours and one indicated that their State statute mandates an investigation within two hours for immediate jeopardy situations. Two States indicated that they have not received immediate jeopardy complaints.

5b. Approximately what percentage of the complaints the agency receives falls into this IJ category?

Table 2 below summarizes the State agency responses by categories of percentages reported.

Table 2

Immediate Jeopardy - Percentage of All Complaints	Number of States
<1%	**10**
1-2%	**11**
>2% and ≤ 5%	**13**
>5% and ≤ 10%	**6**
>10%	**4**

5c. Has the agency promulgated any materials that clarify the definition of Immediate Jeopardy or specify how such complaints should be handled?

Forty-eight States responded to this question. Twenty-three States indicated they have promulgated their own materials to clarify the definition and handling of immediate jeopardy complaints. Of the 25 States that answered negatively to this question, five States indicated they used only the HCFA guidelines while one State uses a draft of Appendix Q of the State Operations Manual.

5d. Does "2 working days" include weekends and holidays?

Twenty-nine (62 percent) of the 47 States responding to this question confirmed that "two working days" for immediate jeopardy investigations does not include weekends and holidays. Eighteen respondents did include weekends and holidays in their two working days time frame.

6. The second category of complaints are those that allege "actual harm" (AH).
6a. Has your agency adopted criteria for distinguishing higher or more serious levels of actual harm from lower levels of actual harm?

Twenty (42 percent) of the 47 State agencies that responded to this question indicated they had adopted some criteria for distinguishing more serious levels of actual harm. Some examples of the criteria mentioned by these State agencies included the HCFA complaint guidance letters, our guidelines for severity and scope of deficiencies, the "age" of the complaint (one doesn't know whether this is how long ago the alleged incident happened or how long the complaint has been in the State's process waiting for investigation), or "other activities known to have occurred in the facility" that may reduce the "severity of concern." (No examples were provided).

The State agencies that indicated they did not develop specific criteria for distinguishing more serious levels of actual harm indicated that they use "common sense, knowledge and experience", HCFA complaint guidance letters that do not distinguish levels of harm, and the HCFA severity and scope definitions.

These responses suggest that there may be significant variability in how States address complaints that involve allegations of actual harm to residents. First, there may be variability in the priority that would be given in the triage process and the assignment of the complaint for an investigation. Second, even the nature of the investigation could be affected by differential standards on the meaning and significance of actual harm.

6b. Do you have a system for prioritizing investigating complaints alleging actual harm?

Again, 47 States replied to this question. Thirty-seven States (79 percent) indicating that they had a system for prioritizing actual harm complaints. Eight of these respondents mentioned the 10-day requirement for investigation of actual harm complaints given in the HCFA guidance letters. Other States commented that they prioritized based on their triage process or based on criteria such as the significance of injury or risk to residents, facility compliance history, or investigator assignments. Although "significance of injury or risk" and "facility compliance history" do seem to relate directly to a complaint, it is uncertain whether using "investigator assignment" as a prioritizing factor may be related to administrative convenience or resource constraints.

6c. Are you able to investigate all complaints involving allegations of actual harm within 10 working days?

Only 13 (28 percent) of the 47 States responding to this question indicated that they were meeting the 10-day time line for completing investigations involving allegations of actual harm. Common reasons given for not meeting the 10-day time line included:

Staff shortages/staff vacancies
Conflicting priorities in using staff, especially trying to meet the statutory requirement for annual surveys
Increases in complaint workload

6d. Are you able to investigate complaints involving "higher levels" of actual harm within 10 working days?

Twenty-one (44 percent) of 48 States responding indicated they were able to investigate the "higher level" actual harm complaints within 10 days. An equivalent number of States answered this question as Not Applicable. Our researchers suspect that this response has to do with the fact, as one State pointed out in its comments, "HCFA has provided no definition that differentiates between higher levels of harm and lower levels of harm." Six State agencies responded that they could not conduct these investigations within 10 days.

The responses to this question raise again the question of whether current survey agency resources are sufficient for the serious task of investigating complaints in a timely manner, and if complaints are investigated in accordance with HCFA guidelines.

6e. Are you able to gather the necessary information, prioritize the complaint, and establish a date for one investigation of ALL actual harm complaints within 10 working days?

Fifty-five percent (26 of the 47 State agencies responding) answered that they could gather necessary complaint information, prioritize it and establish actual harm investigation dates within 10 days. From reviewing the variety of comments about this question, including several States that indicated the question was unclear, one cannot be certain how States answered this question and, consequently, no conclusions were drawn from the responses.

The October 13, 1999 letter, under the section on "**TRIAGE and PRIORITY ASSIGNMENT"** (Page 3), States:

> All information will be gathered and evaluated, the complaint will be prioritized; and the date when the complaint is to be investigated will be scheduled within 10 working days of its receipt, unless there are extenuating circumstances that impede the collection of relevant information within this time frame.

It may be that States did not understand this guidance, especially the justification option related to extenuating circumstances. Whether there is a systematic difference in understanding between State survey agencies contacted by the Regional Offices and State survey agencies that were not contacted by the Regional Offices may become clear in the forthcoming telephone survey.

7. Which of the following other information do you use in prioritizing complaint investigations?

(i) Facility's compliance history
(ii) Facility's Quality Indicator Profile report
(iii) Information from ombudsman program
(iv)..Facility's history of complaints/allegations
(v)...Other (Please explain)

The State agencies' responses to the use of various pieces of information for prioritizing complaints are summarized in **Table 3** below. For the most part, the State agencies appear to use standard information that has previously been available such as compliance history (i.e., deficiencies), complaint history, and ombudsman reports. One can only speculate that the lower use of the Facility Quality Indicator Profile reports has to do with the relative "newness" of the reports, or their use in onsite complaint investigation preparation after the complaint priority has been established as alluded to in a comment from one State agency.

Table 3

Type of Information	**State Responses**	
	Yes	**No**
Facility Compliance History	32 71%)	13 (29%)
Facility Quality Indicator Profile Report	19 (43%)	25 (57%)
Information from Ombudsman	32 (73%)	12 (27%)

Facility History of Complaints/Allegations	35 (78%)	10 (22%)

The State agencies also commented that they considered other items as well. These included source of complaint (e.g., hospitals, media, public representatives), information and guidance contained in SOM Appendix Q – Immediate Jeopardy guidance, and information from other organizations (e.g., Adult Protective Services, Medicaid program, licensure program, Medicaid Fraud and Abuse programs, surveillance and utilization review programs and law enforcement). The comments provided did not explain how States assigned relative value to any of these sources.

8. Do you think the volume of complaints has increased, decreased or stayed about the same since October 1999?

Forty-eight States responded to this question. Thirty-four (71 percent) believed the volume of complaints has increased while 13 States believe the volume was about the same. Only one State reported that it had seen a decrease (of 60 percent in FY 2000).

9. Do you think the seriousness of complaints has increased, decreased or stayed about the same since October 1999?

Forty-eight States also responded to this question. Thirty-one States (65 percent) were of the opinion that the seriousness of complaints had stayed about the same. The other seventeen States believed that the seriousness had increased. One State commented that an improved labor market with resulting staffing problems, changes in Medicare reimbursement, and heightened awareness by consumers were factors that contributed to the increase in the seriousness of complaints.

10. Does your system (either electronic or manual tracking system) currently allow you to report the number of complaints the agency receives that allege immediate jeopardy?

The majority of the 48 States answering this question stated that they had either an electronic or manual tracking system in place for immediate jeopardy complaints. Thirty-eight States (79 percent) had such systems while 10 States did not.

11. ***Does your system (either electronic or manual tracking system) currently allow you to report the number of complaints the agency receives that allege actual harm?***

Curiously, fewer States had an electronic or manual tracking system for complaints that involved allegations of actual harm. Of the 48 States responding, 32 (67 percent) had such systems.

12. ***Please indicate the date on which your system (either electronic or manual tracking) became capable of reporting the number of complaints and differentiating between immediate jeopardy and alleged actual harm. (Check the Not Applicable response if your system cannot currently do this.)***

Forty-six States responded to this question. Fourteen States (30 percent) responded that their systems were currently not capable of reporting numbers of complaints and differentiating between immediate jeopardy and actual harm. Table 4 (below) lists the number of State agencies that reported they were capable of reporting this data by the date on which they first became capable. Thus, only on the 31 States that asserted that they had a tracking system capable of distinguishing between complaints by type of complaint are reported here. One State responded they had a manual system capable of providing this information but did not give a date.

Table 4	
Capability Date	**Number of States**
1986	1
1989	1
October 1991	1
1993	1
January 1994	3
October 1997	1
April 1998	1
August 1998	1
January 1999	1
March 1999	1
April 1999	2
June 1999	1
July 1999	1
August 1999	1
October 1999	6
January 2000	2
February 2000	2
March 2000	3
April 2000	1
Total	31

Appendix C
State Level Tables on Staggered Surveys

Appendix D
Tables of State-by-State Data

Appendix E
Maps of State-by-State Differences in Resident Characteristics

Appendix F
History of Nursing Home Enforcement

History of Nursing Home Enforcement

Some 1.6 million elderly and disabled people receive care in approximately 17,000 nursing homes across the United States. The Federal government provides funding to States to conduct on-site inspections and recommend sanctions for violations of health and safety rules by facilities participating in Medicare and Medicaid. State Medicaid programs fund care for approximately two-thirds of nursing home residents, and Medicare finances care for about 10 percent. Protecting nursing home residents and ensuring that they receive the quality of care and protection they deserve is a priority for our Agency and this Administration. We are committed to working with residents, their families, advocacy groups, providers, States, and Congress to fully and effectively implement the President's NHI. This section of the report provides background and history on nursing home enforcement and the President's Nursing Home Initiative.

Federal Oversight of Survey and Certification

Formal Federal involvement in the regulation of nursing homes dates to 1965, when the Medicare and Medicaid programs were enacted. Requirements for nursing home operators to be in compliance with Federal standards became fully effective in the summer of 1970 (Health Care Financing Administration 1998). In the 1970s and 1980s, newspaper articles, books and Congressional hearings documented widespread and scandalous problems in nursing home quality of care (Mendelson, 1974; Vladeck, 1980; Moss, 1977 ; The Health Care Financing Administration, 1998). In response to a ruling by the Tenth Circuit Court of Appeals in 1984, the Department of Health and Human Services began to develop a nursing home survey process that reviewed outcomes of resident care (Spector and Drugovitch 1989). Further changes were proposed by HCFA in 1987, just before passage of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), which codified many of the proposed regulatory changes (Health Care Financing Administration 1998).

1986 Institute of Medicine Report

Amid growing concern about quality of care in nursing homes during the early 1980s, and the acknowledgment by both Federal and State regulatory agencies that external quality review systems alone fell short of measuring quality, the Congress and HCFA, in 1983, commissioned an important study on nursing home quality to be conducted by the Institute of Medicine (IOM). The IOM study, *Improving the Quality of Care in Nursing Homes* (1986), confirmed the reports of widespread quality of care problems and recommended strengthening Federal regulations for nursing homes (Institute of Medicine 1977). The IOM reported that Federal regulations encouraged facilities to comply with Federal standards, but did not have adequate sanctions. At that time, the major sanction for noncompliance was to require a plan of correction and eventually to remove a facility's Federal certification, thereby eliminating its eligibility to receive Federal payment for services. The IOM recommended new and stronger enforcement activities and remedies with intermediate sanctions, plus many other sweeping recommendations to improve the regulation of nursing homes.

The Omnibus Budget Reconciliation Act of 1987 (OBRA '87)

The IOM and GAO recommendations,[9] as well as the active efforts of many consumer advocacy and professional organizations, resulted in Congress passing a major reform of nursing homes regulation in OBRA '87, the first significant changes since Medicare and Medicaid were adopted in 1965 (1987). This 1987 nursing home reform law embraced the findings and recommendations of the IOM and the GAO reports by strengthening both regulatory standards and the survey and enforcement processes.

OBRA '87 defined the role of the State survey and certification process in determining nursing homes' compliance with Federal standards and adopted new enforcement procedures with intermediate remedies and sanctions, in addition to the decertification procedures for facilities that fail to meet Federal standards.

The OBRA '87 standards, implemented in 1990 for nursing homes, were intended to ensure that each resident achieves his or her highest practicable level of physical, mental and psychosocial well being, instead of solely monitoring facility policy and procedures. In connection with the new requirements, HCFA implemented an outcome-oriented survey system for determining nursing home compliance with the new standards. Surveyors conducted interviews with residents to obtain their views on the care and treatment they receive in the home. For the first time, the focus was on the nursing home resident and the adequacy of the quality of care for that resident.

Resident Assessment Instrument

OBRA '87 also required that HCFA implement a standardized resident assessment instrument, the RAI, to be used by all nursing homes participating in the Medicare and Medicaid programs to periodically assess a resident's functional capacity.[10] The RAI consists of a minimum data set (MDS) and Resident Assessment Protocols (RAPs)(Health Care Financing Administration 1995). The information from the MDS and RAPs form the basis for individualized care planning. Implementation of a single assessment process in all the nation's nursing homes provided, in many cases, information never before available for care planning to meet residents' needs.

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[9] In 1987, the General Accounting Office (GAO) reported that over one-third of the nation's nursing homes were operating at a substandard level, below minimum Federal standards during three consecutive inspections (The General Accounting Office 1987).

[10] The statutory authority for the MDS and the RAI is found in §1819(f)(6)(A) and (B) and §1919(f)(6)(A) and (B) of the Act, as amended by OBRA '87. These sections of the Act required the Secretary of HHS to specify a minimum data set of core elements to use in conducting comprehensive assessments. It further required the Secretary to designate one or more resident assessment instruments based on the minimum data set. The Secretary designated Version 2.0 of the RAI in the State Operations Manual Transmittal #272, issued April 1995.)

July 1995, Implementation of the Enforcement Provisions of OBRA '87

On July 1, 1995, the new enforcement regulation was implemented. The intent of the new enforcement process was to provide solutions to several long-standing problems in Federal regulation, including: the lack of intermediate sanctions; cyclical nursing home compliance (chronically in, then out of, compliance); and the potentially lengthy intervals between identification of a nursing home's compliance problem and its correction (Vladeck 1996). The rule set forth the premise that every problem was a deficiency and deficient providers would be appropriately sanctioned. This rule set the expectation that surveyors would arrive at a conclusion about the seriousness of each identified deficiency based on an evaluation of its severity and scope (1994). Deficient nursing home providers would be swiftly and appropriately sanctioned, with enforcement remedies linked to the seriousness of the deficient practice.

In changing its processes, HCFA attempted to strengthen enforcement and improve survey procedures, with the overarching goal of improving care and quality for nursing home residents. The enforcement regulation set forth the expectation that providers, in order to maintain compliance and be successful, must have an active process to identify and fix their own deficiencies.

1998 HCFA Report to Congress and GAO Study

In July 1998, we released a Report to Congress documenting that the regulations on the new long-term care conditions of participation had helped to improve the health and safety of nursing home residents. Specifically:

- Over-use of anti-psychotics had declined from about 33 percent to 16 percent;
- Appropriate use of anti-depressants had increased, from 12.6 percent to 24.9 percent;
- Use of physical restraints had declined from about 38 percent to under 15 percent;
- Use of indwelling urinary catheters had declined by nearly 30 percent; and,
- The number of residents with hearing problems who had received hearing aids was up 30 percent.

However, the report also made clear that several areas required greater attention. Residents continued to suffer form easily prevented problems such as bed sores, malnutrition, and dehydration, as well as from abuse, neglect, and misappropriation of property. Inspections were easily predicted. And several States had only rarely cited homes for substandard care.

Also in July 1998, the General Accounting Office (GAO) released a report on California nursing homes which confirmed and expanded on these findings (California Nursing Homes: Federal and State Oversight Inadequate to Protect Residents in Homes with Serious Care Violations). The GAO report found that, while many homes are committed to providing the best environment for their residents, others are either unable or unwilling to do so. It also found that Federal and State oversight and enforcement in homes providing less than acceptable care was often inadequate, and made clear that HCFA needed to do a better job to monitor the troubled homes and take appropriate and meaningful actions to either prompt these homes to correct their problems or prevent them from participating in its programs. To

address these problems, GAO suggested, among others, the following changes to HCFA's survey and enforcement processes:

- Staggering survey schedules;
- Increasing the sample size for nutrition, dehydration and pressure sore areas;
- Eliminating grace periods for homes with repeated serious violations; impose remedies promptly; and,
- Requiring, for problem homes, an onsite visit to substantiate a home's claim that deficiencies have been corrected.

Presidential Initiatives - July 1998

On July 21, 1998, the President announced a series of major new steps to increase Federal oversight of nursing homes' performance and improve the quality of care and life for vulnerable nursing home residents. These new activities include:

- Enhanced monitoring of poorly performing homes;

- Imposition of swift and certain sanctions when inadequate care is identified;

- Action to reduce the incidence of bed sores, malnutrition, dehydration, and resident abuse by developing new survey protocols to detect quality problems in nursing homes;

- A national campaign to educate residents, families, consumers, nursing home staff, and the public about the risks of malnutrition and dehydration, as well as nursing home residents' rights to quality care. A related campaign emphasized the prevention of abuse and neglect of nursing home residents;

- Establishing a HCFA web site, which allows consumers to compare survey results and safety violations when choosing a nursing home, and contains best practice guidelines for at-risk residents;

- Staggering or otherwise varying the scheduling of surveys to reduce the predictability of surveyor visits. Under this protocol, State survey agencies must conduct at least 10 percent of nursing home standard surveys on weekends, in the early morning, or in the evening;

- Rapidly sanctioning any facility a) found in serious noncompliance; b) with a history of termination from Medicare and/or Medicaid programs; or c) in which, in the judgement of HCFA and the State, immediate action is warranted and sanctions should be imposed without giving the facility an opportunity to correct its problems.

- Inspecting problem facilities twice as often so that persistent problems can be addressed quickly with no decrease in inspections of other facilities;

- Issuing final regulations in March 1999 that allow States to impose a civil monetary penalty of up to $10,000 for each serious incident;

- Requiring that States investigate complaints alleging harm to residents within 10 days;

- Encouraging the effective use of drugs through revised manual guidelines and increased training to States; and,

- Working with the Department of Justice to prosecute the most egregious violations.

1999 GAO Reports

In March 1999, the GAO issued a study entitled, "Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents." In that study, GAO recommended that HCFA develop additional standards, including maximum time frames for the prompt investigation of serious complaints alleging non-immediate jeopardy harm to residents as well as for complaints that are deferred until the next survey; strengthen Federal Oversight of State Complaint Investigations; and, require that substantiated results of complaint investigations be included in Federal Data Systems or be accessible to Federal officials.

In response to these recommendations, HCFA directed States to investigate any complaint alleging harm within 10 days and reemphasized existing guidance on time frames for investigating all other complaints. To help in defining alleged actual harm, HCFA issued additional guidance to Regional Office and States.[11]

In November 1999, the GAO issued another study demonstrating the need for greater consistency among HCFA Regional Offices in oversight of State survey agencies and other nursing home enforcement efforts. We responded by redirecting our State Agency Quality Improvement Program to be a consistent national program directly tied to measurable performance standards. We also refined protocols for Federal oversight of State surveyors and strengthened efforts to more consistently conduct comparative surveys, where HCFA staff perform an independent review of a given facility after a State agency has finished its survey.

[11] See Section 1.5 for more discussion of the implementation of new complaint investigation protocols.